



# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of Occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)*. For persons who have no occupation whatever, write *None*.

**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menn-*

ges

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . .  
name origin; "Cancer" is less definite; avoid use of  
"Tumor" for malignant neoplasms; *Measles*, *Whooping*  
*cough*; *Chronic valvular heart disease*; *Chronic interstitial*  
*nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important.  
Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For VIOLENT DEATHS state MEANS OF INJURY and QUALITY as ACCIDENTAL, SUICIDAL, OR HOMICIDAL, OR AS PROBABLY SUCH, IF IMPOSSIBLE TO DETERMINE DEFINITELY. Examples:  
*Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbonic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions unanswered in detail, it will prevent further correspondence. All the duty is personal and must be obtained before this certificate is permanently filed.

4 1915

BUTTERFAU, V.S.

RECEIVED	SEP 16 1915
BUREAU, V.S.	

*Send out for signature*

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH Cecil S 6458

County

Village or City

2 FULL NAME

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male white

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

6 DATE OF BIRTH

May 13, 1915

(Month) (Day) (Year)

7 AGE

..... yrs. .... mos. .... ds. If LESS than  
1 day, ..... hrs. OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work

(b) General nature of Industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE

(State or country)

PARENTS

10 NAME OF  
FATHER

G. T. Brown

11 BIRTHPLACE  
OF FATHER  
(State or country)

Cecil Co. Md

12 MAIDEN NAME  
OF MOTHER

Annie Walker

13 BIRTHPLACE  
OF MOTHER  
(State or country)

Cecil Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Annie Brown

(Address)

Perryville Md

15

Filed May 13, 1915 V. S. No. 1

REGISTRAR

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 96

St.: Ward)

Brown

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 13

, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY That I attended deceased from  
May 13<sup>rd</sup>, 1915 to May 13<sup>rd</sup>, 1915, 1915

that I last saw h. alive on , 1915

and that death occurred on the date stated above, at m.

The CAUSE OF DEATH\* was as follows:

This child was born dead

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Geo. M. Steepe M. D.  
May 13, 1915 (Address) Perryville Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL DATE OF BURIAL

Hopewell Cemetery May 13, 1915

20 UNDERTAKER ADDRESS

W.C. Jackson Blythdale

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

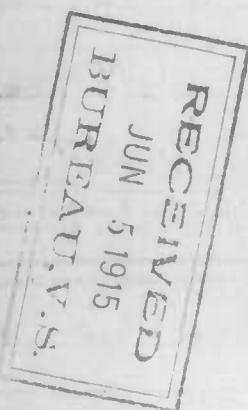
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary fireman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mining, etc.* Women at home, who are engaged in the duties of the household only (not paid *Hausekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum, etc., Cervic-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Traenia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicemia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

V. S. No. 1.  
WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD  
N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS  
should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of  
OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

6459

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

St.; Ward)

[If death occurred in  
a hospital or institution,  
give its NAME instead  
of street and number.]Village or City near Port Deposit

2 FULL NAME

Howard C Clark

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDOWED OR DIVORCED <u>married</u> (Write the word)
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6 DATE OF BIRTH

July 24, 1879

(Month) (Day) (Year)

7 AGE

38 yrs. 10 mos. 4 ds.If LESS than  
1 day. hrs.  
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work Laborer Railroad
- (b) General nature of industry business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Cecil Co. Md

PARENTS

10 NAME OF FATHER

Edward Clark11 BIRTHPLACE OF FATHER  
(State or country)Cecil Co. Md

12 MAIDEN NAME OF MOTHER

Mary Fisher13 BIRTHPLACE OF MOTHER  
(State or country)Cecil Co. Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Bettie Brown

(Address)

Port Deposit Md

15

Filed May 30, 1915

If more blanks are needed, address State Registrar, 16 W. Saratoga St., Balt., Requesting V. S. No. 1.

REGISTRAR

19 PLACE OF BURIAL OR REMOVAL

Chestertown Cemetery

DATE OF BURIAL

May 30, 1915

20 UNDERTAKER

W C Jackson Blythdale

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *menin-*

*ges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*, *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intervening) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Col-lapse," "Coma," "Convulsions," "Debility," ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death, state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED	JUN 5 1915
BUREAU, V.S.	

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

6460

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

If death occurred in a hospital or institution, give its NAME instead of street and number.

Village or City Elkton (No. 131) St. Mem Hospital Ward)

## 2 FULL NAME

Marta Cooper

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>Black</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Married</u>
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6 DATE OF BIRTH not known,  
(Month) (Day) (Year)

7 AGE 57 yrs. — mos. — ds. If LESS than  
1 day, .... hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work Housenp  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) —

9 BIRTHPLACE  
(State or country) Delaware

10 NAME OF  
FATHER Samuel Blackom

11 BIRTHPLACE  
OF FATHER  
(State or country) Delaware

12 MAIDEN NAME  
OF MOTHER Unknown

13 BIRTHPLACE  
OF MOTHER  
(State or country) Unknown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Anna Cooper  
(Address) Middleton Del

15 FILED May 18, 1915 S. Frank Foyne  
REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 17, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 16, 1915, to May 17, 1915,

that I last saw her alive on May 17, 1915,

and that death occurred on the date stated above, at 7 P.M.

The CAUSE OF DEATH\* was as follows:

Exhaustion from Cancer of  
of great size  
(Duration) 7 yrs. — mos. — ds.

Contributory Secondary Inflammation  
(Duration) yrs. — mos. — ds.

(Signed) Henry McKey, M.D.  
3718, 1915 (Address) Elkton Del

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. in the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, if not at place of death? near Middleton Del

Former or usual residence Middleton Del.

19 PLACE OF BURIAL OR REMOVAL Greenspring Del DATE OF BURIAL May 21, 1915

20 UNDERTAKER Andrew J. Green ADDRESS Middleton Del.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "*Anæmia*," "*Anæmia*" (merely symptomatic), "*Atrophy*," "*Collapse*," "*Coma*," "*Convulsions*," "*Debility*" ("*Conseitual*," "*Seuile*," etc.), "*Dropsey*," "*Exhaustion*," "*Heart failure*," "*Hæmorrhage*," "*Inanition*," "*Marnus*," "*Old Age*," "*Shock*," "*Uraemia*," "*Weakness*," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1915

BUREAU U. S.

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1 PLACE OF DEATH  
County Cecil

6461

100

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Elkton (No. \_\_\_\_\_)

## 2 FULL NAME

Mary Elizabeth Cantwell Ells

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Female</u>	<u>White</u>	<u>Widow</u>

## 6 DATE OF BIRTH

—, —, 1\_\_\_\_\_  
(Month) (Day) (Year)

## 7 AGE

74 yrs. — mos. — ds.  
It LESS than  
1 day, \_\_\_\_ hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

Housewife

## 9 BIRTHPLACE

(State or country)

Ind

## 10 NAME OF FATHER

Robert Cantwell

## 11 BIRTHPLACE OF FATHER

(State or country)

Ind

## 12 MAIDEN NAME OF MOTHER

Elyza Brown

## 13 BIRTHPLACE OF MOTHER

(State or country)

Ind

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

F P Price

(Address)

Elkton

## 15

Mary

1915

Jeanne Frazer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from January 22, 1915, to May 13, 1915,

that I last saw h.e. alive on May 13, 1915,

and that death occurred on the date stated above, at 8 a.m.,  
The CAUSE OF DEATH\* was as follows:

Chronic Parenchymalosis

Nephritis

(Uræmia)

Indefinite (Duration) 1 1/2 yrs. mos. ds.

## Contributory

Secondary

(Duration) yrs. mos. ds.

(Signed) Howard Bradon, M.D.  
May 14, 1915 (Address) Elkton Md

\* State the DISEASE CAUSING DEATH, or, if deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Elkton Cemetery

DATE OF BURIAL  
May 15, 1915

## 20 UNDERTAKER

Visinger & Sons

ADDRESS  
Elkton

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

### Statement of cause of death

Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*TUERPERAL septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 4 1915

BUREAU U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County *Baltimore*

6462

(22)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *95*

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City *Near Rising Sun, Md.*2 FULL NAME *Susan Anna Eulie*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<i>Female</i>	<i>white</i>	<i>Married</i>

6 DATE OF BIRTH	October 26, 1894
	(Month) (Day) (Year)

7 AGE	71 yrs. 6 mos. 21 ds.	IT LESS than 1 day, ____ hrs. OR ____ min. ?
-------	-----------------------	--

8 OCCUPATION	<i>Housewife</i>
(a) Trade, profession, or particular kind of work.	
(b) General nature of industry, business, or establishment in which employed (or employer)	

9 BIRTHPLACE (State or country)	<i>Maryland</i>
------------------------------------	-----------------

10 NAME OF FATHER	<i>Benjamin Reynolds</i>
-------------------	--------------------------

11 BIRTHPLACE OF FATHER (State or country)	<i>Maryland</i>
---	-----------------

12 MAIDEN NAME OF MOTHER	<i>Susan Hill</i>
--------------------------	-------------------

13 BIRTHPLACE OF MOTHER (State or country)	<i>Maryland</i>
---	-----------------

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant)	<i>Miss Frances Cooper</i>
---	----------------------------

15 ADDRESS	<i>Rising Sun, Md.</i>
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16 FILLED	<i>1915</i>
-----------	-------------

*Louise M. Washington*

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH *5 19*, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from *May 1*, 1915, to *May 19*, 1915,

that I last saw her alive on *May 19*, 1915,

and that death occurred on the date stated above, at *11 a.m.*

The CAUSE OF DEATH\* was as follows:

*Bright's disease*

*About two years*

(Duration) — yrs. — mos. — ds.

Contributory  
Secondary

(Duration) — yrs. — mos. — ds.

(Signed) *J. B. Slocum*, M. D.

*5/19, 1915* (Address) *Rising Sun, Md.*

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted, \_\_\_\_\_  
It not at place of death? \_\_\_\_\_

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL *Clinic M. E. Church* DATE OF BURIAL *5/21, 1915*

20 UNDERTAKER *Daniel Taylor* ADDRESS *101 W. Franklin St., Baltimore, Md.*

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary Foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Mosches*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPEAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 3 1915

BURR: A.U.V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH Cecil County		6437	STATE OF MARYLAND CERTIFICATE OF DEATH
Village or City	Elkton Union Hospital (No.)		Registration Dist. No. 92
2 FULL NAME David Ferguson		St. Ward	[If death occurred in a hospital or institution, give its NAME instead of street and number.]
PERSONAL AND STATISTICAL PARTICULARS			
3 SEX Male	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Single	
6 DATE OF BIRTH April 30, 1865 (Month) (Day) (Year)		10 DATE OF DEATH May 31, 1915 (Month) (Day) (Year)	
7 AGE 50 yrs. 1 mos. 1 ds.	If LESS than 1 day, hrs. OR min. ?		I HEREBY CERTIFY, That I attended deceased from
8 OCCUPATION (a) Trade, profession, or particular kind of work. Laborer		that I last saw him alive on	
(b) General nature of industry, business, or establishment in which employed (or employer) Day Laborer cutting timber & fishing		and that death occurred on the date stated above, at m,	
9 BIRTHPLACE (State or country) Md		The CAUSE OF DEATH* was as follows: Homicide Gun shot wound of chest through & abdomen	
10 NAME OF FATHER Wm Ferguson		Contributory Secondary	
11 BIRTHPLACE OF FATHER (State or country) Md		12 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place yrs. mos. ds. to the State yrs. mos. ds.	
12 MAIDEN NAME OF MOTHER Katherine Marston		Where was disease contracted, if not at place of death?	
13 BIRTHPLACE OF MOTHER (State or country) Md		Former or usual residence	
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) Mrs Rachel Ferguson (Address) North East			
15 Filed June 3, 1915 - J. Brown Fraser		19 PLACE OF BURIAL OR REMOVAL North East Cemetery	
		DATE OF BURIAL June 3, 1915	
		20 UNDERTAKER Vining & Sippel	ADDRESS Elkton MD
1 If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.			

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and quality as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUL 6 1915

BUREAU OF THE CENSUS

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Baltimore

Village or City Elkton (No.)

6463

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Clara V. Freeman

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female 4 COLOR OR RACE White 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED married  
(Write the word)

6 DATE OF BIRTH Dec 28, 1867  
(Month) (Day) (Year)

7 AGE 47  
47 yrs. 6 mos. ds. It LESS than  
t day, hrs. OR min. ?

8 OCCUPATION House wife  
(a) Trade, profession, or particular kind of work.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE Ind  
(State or country)

10 NAME OF FATHER James H. Scott

11 BIRTHPLACE OF FATHER Ind  
(State or country)

12 MAIDEN NAME OF MOTHER Sarah N. Crawford

13 BIRTHPLACE OF MOTHER Ind  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Thomas Freeman

(Address) Elkton

15 Date May 14, 1915 If dead J. Frazer Frazier

REGISTRAR

(1)

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 13, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 5, 1915, to May 13, 1915,

that I last saw her alive on May 13, 1915,

and that death occurred on the date stated above, at 2:10 A.M.

The CAUSE OF DEATH\* was as follows:

Appendectomy  
(Duration) yrs. mos. ds.

Contributory  
Secondary

H. M. D. Cawley, M. D.  
(Duration) yrs. mos. ds.  
(Signed) H. M. D. Cawley, M. D.  
, 1915 (Address) Elkton, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
It not at place of death?

Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL Bethel Cemetery DATE OF BURIAL May 15, 1915

20 UNDERTAKER Vining & Offin ADDRESS Elkton

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, theisease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*, *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*oma, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con-senital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deatus state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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**RECEIVED**  
JUN 4 1915  
BUREAU, U.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County Cecil

6464

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 90Village or City Calvert (No.)

St.: Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Howard Franklin Gibson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

4 COLOR OR RACE

MaleWhite5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Single

6 DATE OF BIRTH

Feb 4, 1914  
(Month) (Day) (Year)

7 AGE

1 yrs. 3 mos. 6 ds.If LESS than  
1 day, hrs.  
OR min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work Not any
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE

(State or country)

10 NAME OF FATHER

Amos Whitteman Gibson11 BIRTHPLACE OF FATHER  
(State or country)Cecil Co. Md.

12 MAIDEN NAME OF MOTHER

Tillie Churchman13 BIRTHPLACE OF MOTHER  
(State or country)Cecil Co. Md.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Amos W. Gibson(Address) Rising Sun, Md.

15

Filed June 11, 1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 12, 1915  
(Month) (Day) (Year)I HEREBY CERTIFY, That I attended deceased from Mar 20th, 1915 to May 10th, 1915,that I last saw him alive on May 3rd, 1915,and that death occurred on the date stated above, at 2 A.M.

The CAUSE OF DEATH\* was as follows:

Cerebral meningitis(Duration) 2 mos. 10 ds.Contributory  
SecondaryNo other known cause(Duration) 2 mos. 10 ds.

(Signed)

D. H. Gifford M. O.  
May 12, 1915 (Address)

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ In the \_\_\_\_\_  
of death yrs. mos. ds. State yrs. mos. ds.Where was disease contracted,  
It not at place of death?Former or  
usual residence.....

19 PLACE OF BURIAL OR REMOVAL

Rosebank, Md. May 12, 1915 (Date of Burial)

20 UNDERTAKER

B. E. Mason ADDRESS  
Nottingham R. L. Pa.

(1) If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Houselabor*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report, "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Miasics* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 ds. Never report more symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL pyrithonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	JUN 3 1915
BUREAU U. S.	

## MARGIN RESERVED FOR BINDING

WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil  
Village or City Near Oakwood (No. 6465)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 7a

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

George W Green

## 2 FULL NAME.....

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>married</u> (Write the word)
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## 6 DATE OF BIRTH

Jan 1, 1878  
(Month) (Day) (Year)

## 7 AGE

37 yrs 4 mos 16 ds. If LESS than  
1 day, \_\_\_\_ hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work Laborer  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)

## 10 NAME OF FATHER

Millard Carroll11 BIRTHPLACE OF FATHER  
(State or country)Penn

## 12 MAIDEN NAME OF MOTHER

Eliza Green13 BIRTHPLACE OF MOTHER  
(State or country)Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Charles A Green(Address) Oakwood Md.

## 15

Filed May 18, 1915, at St. C. Cannon

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 16, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from \_\_\_\_\_, 191\_\_\_\_, to \_\_\_\_\_, 191\_\_\_\_,

that I last saw him alive on \_\_\_\_\_, 191\_\_\_\_,

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Dislocated neck from a fall in an attack of epileptic convulsions

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Contributory  
Secondary

(Duration) \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

(Signed) Wm P Deasy Coroner  
(Address) Baltimore Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Bethesda Cemetery20 UNDERTAKER Slater B. Tuck

## DATE OF BURIAL

May 19th, 1915

## ADDRESS

Coloarmd

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer or Planter, Physician, Compositor, Architect, Locomotive engineer, Civil engineer, Stationary foreman, etc.* But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home*, and children, not gainfully employed, as *At school or At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: Measles (disease causing death), 29 d.; Bronchopneumonia (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED	JUN 5 1915	BUREAU U.S.A.
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## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County *Kent*

Village or City *Gowntown* (No.)

2 FULL NAME *Kenneth Hoefer*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX *Male* 4 COLOR OR RACE *white* 5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word) *Single*

6 DATE OF BIRTH

*May 21, 1915*  
(Month) (Day) (Year)

7 AGE

yrs. .... mos. .... If LESS than  
 9 yrs. 1 day, .... hrs.  
 OR min. ?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work. *None*
- (b) General nature of industry, business, or establishment in which employed (or employer) *None*

9 BIRTHPLACE

(State or country) *Md*

PARENTS

10 NAME OF FATHER *Ernest Hoefer*

11 BIRTHPLACE OF FATHER  
(State or country) *Md*

12 MAIDEN NAME OF MOTHER *Helen Taylor*

13 BIRTHPLACE OF MOTHER  
(State or country) *Md*

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) *Helen Hoefer*

(Address) *Elkton 153*

15

*May 22, 1915* *Helen Hoefer*

REGISTRAR

6466

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. *92*

St. *Ward*)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May 22, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

, 191..., to

that I last saw him alive on *May 21, 1915*

and that death occurred on the date stated above, at *7 a.m.*

The CAUSE OF DEATH\* was as follows:

*Pneumonia*

— (Duration) — yrs. — mos. — ds.

Contributory  
Secondary

*C.P. Coughed up mucus* (Duration) yrs. mos. ds.  
(Signed) *May 22, 1915* (Address) *Baltimore, Md.* M. D.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL *Chesapeake* DATE OF BURIAL *May 22, 1915*

20 UNDERTAKER *A. J. Crowley* ADDRESS *Chesapeake* *Md.*

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Grouper"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*

"oma, Sarcoma, etc., of..... (name origin: "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or concurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Coughful," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1915

BUREAU U.S.A.

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## 1 PLACE OF DEATH

County Cecil

6467

(79)

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 9

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City St. Augustine (No. \_\_\_\_\_)2 FULL NAME Geo A. Stoyan

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
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## 6 DATE OF BIRTH

16 July, 1888  
(Month) (Day) (Year)

## 7 AGE

57 yrs 1 mos 21 ds.  
If LESS than  
1 day, \_\_\_\_ hrs.  
OR min. ?

## 8 OCCUPATION

- (a) Trade, profession, or particular kind of work. Sitter  
 (b) General nature of industry, business, or establishment in which employed (or employer) \_\_\_\_\_

9 BIRTHPLACE  
(State or country) Maryland10 NAME OF FATHER Geo. A. Stoyan11 BIRTHPLACE OF FATHER  
(State or country) Maryland12 MAIDEN NAME OF MOTHER Marie P. Peacock13 BIRTHPLACE OF MOTHER  
(State or country) Maryland

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Sarah Thomas

(Address) Chesapeake City, Md.

15

Filed 5/25/1915 at St. Augustine

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

\_\_\_\_\_ to \_\_\_\_\_, 191\_\_\_\_\_, 191\_\_\_\_\_, 191\_\_\_\_\_

that I last saw h. \_\_\_\_\_ alive on \_\_\_\_\_, 191\_\_\_\_\_, 191\_\_\_\_\_

and that death occurred on the date stated above, at \_\_\_\_\_ m.,

The CAUSE OF DEATH\* was as follows:

Found dead in bed  
by J. Jackson Shadwell

(Duration) yrs. mos. ds.  
Contributory Cardiac Asthma  
Secondary

(Duration) yrs. mos. ds.  
(Signed) Wm P. Dean Cor, M. D.  
(Address) Taylor Rd.  
, 191\_\_\_\_\_, 191\_\_\_\_\_, 191\_\_\_\_\_

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_  
Where was disease contracted, \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds  
It not at place of death? \_\_\_\_\_

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL St. Augustine Cemetery, Cecil Co., Md. DATE OF BURIAL May 27, 1915

## 20 UNDERTAKER

W. J. Wilson Undertaker  
ADDRESS 101 Franklin St., Balto.

(1)

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

deel

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

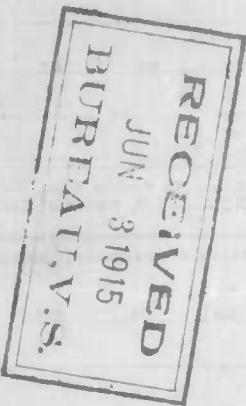
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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Berlil

6488 189

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Near Gion (No.)

St. \_\_\_\_\_ Ward)

## 2 FULL NAME

Charles E. Johnson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>Male</u>	<u>White</u>	<u>Married</u>

6 DATE OF BIRTH  
July 15, 1843  
(Month) (Day) (Year)

7 AGE  
71 yrs. 9 mos. 18 ds.  
If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work Farmer  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Bucks Co. Pa.

10 NAME OF  
FATHER Levi Johnson

11 BIRTHPLACE  
OF FATHER  
(State or country) Bucks Co. Pa.

12 MAIDEN NAME  
OF MOTHER Mary K. Alderman

13 BIRTHPLACE  
OF MOTHER  
(State or country) Bucks Co. Pa.

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John W. Johnson,

(Address) Oxford, Pa.

15

Filed

1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 3rd, 1915  
(Month) (Day) (Year)

I HEREBY CERTIFY, That I attended deceased from November 1914, to May 3rd, 1915,

that I last saw him alive on May 1st, 1915, and that death occurred on the date stated above, at 3 P.M.

The CAUSE OF DEATH\* was as follows:

Measles, Pox

No rashes - TB  
(Duration) 6 mos. 5 ds.

Contributory  
Secondary

17 (Duration) 2 days yrs. mos. ds.

(Signed) W. D. Goff M.D.  
May 3rd, 1915 (Address) North East End

\*State the DISEASE CAUSING DEATH, or, In deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. mos. ds. In the State \_\_\_\_\_ yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Rosebank Md DATE OF BURIAL May 7, 1915

20 UNDERTAKER B. E. Mason

ADDRESS  
Hollingsham  
R.R. 62

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *farmer* or *planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Labourer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Cotton mill*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

## Statement of cause of death—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples:

*Epidemic cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonacum*, etc., *Carcin-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.s.; *Bronchopneumonia* (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Anemia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal pueritis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 3 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

6468

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 91Village or City St. Augustines (No.)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Oscar William Henry Jones

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male.</u>	4 COLOR OR RACE <u>Petite</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
--------------------	-------------------------------	--

6 DATE OF BIRTH March 18  
(Month) (Day) (Year) , 1844

7 AGE 71 yrs. 2 mos. 10 ds. If LESS than  
1 day.....hrs.  
OR min.?

8 OCCUPATION Laborer  
(a) Trade, profession, or particular kind of work  
(b) General nature of industry, business, or establishment in which employed (or employer) Construction

9 BIRTHPLACE Maryland  
(State or country)

10 NAME OF FATHER Dent Knew

11 BIRTHPLACE OF FATHER Dent Knew  
(State or country)

12 MAIDEN NAME OF MOTHER Dent Knew

13 BIRTHPLACE OF MOTHER Dent Knew  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Jane Johnson

(Address) St. Augustines

15 Filed 5/25/1915 S. Sawtelle

REGISTRAR

I if more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 25  
(Month) (Day) (Year) , 1915

17 I HEREBY CERTIFY, That I attended deceased from March, 1915, to March, 1915,

that I last saw him alive on March 10, 1915,

and that death occurred on the date stated above, at 6 a.m.

The CAUSE OF DEATH\* was as follows:

Paralytic & Arterio-Sclerosis

(Duration) 8 yrs. 6 mos. 6 ds.

Contributory Secondary Perforating Softening

(Duration) yes mos. ds.

(Signed) Elmer D. Lovitz, M.D.  
May 25, 1915 (Address) Physician Ref. 2nd

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_  
of death \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the \_\_\_\_\_ State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds.

Where was disease contracted,  
if not at place of death? \_\_\_\_\_

Former or  
usual residence \_\_\_\_\_

19 PLACE OF BURIAL OR REMOVAL Concord Burial Ground DATE OF BURIAL May 27th, 1915

20 UNDERTAKER John Clappier ADDRESS Physician Ref. 2nd

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

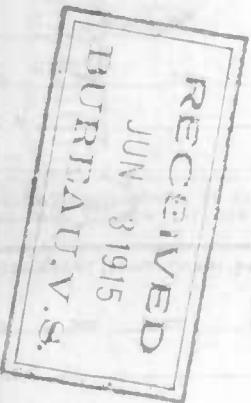
[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as accidental, suicidal, or homicidal, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—decapitated*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

S 6469

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92Village or City Ecklon (No. 100)

Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Unnamed

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> <small>(Write the word)</small>
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6 DATE OF BIRTH May 15, 1915  
(Month) (Day) (Year)

7 AGE <u>Stillborn</u>	if LESS than 1 day.....hrs. OR.....min.?
------------------------	--

8 OCCUPATION  
 (a) Trade, profession, or particular kind of work  
 —  
 (b) General nature of industry, business, or establishment in which employed (or employer)  
 —

9 BIRTHPLACE  
(State or country) Ecklon Md.

10 NAME OF FATHER Elwood J Kirk

11 BIRTHPLACE OF FATHER  
(State or country) Celt Co Md

12 MAIDEN NAME OF MOTHER Fannie Bessie J Lovelace

13 BIRTHPLACE OF MOTHER  
(State or country) Chesapeake City Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Elwood J Kirk

(Address) Chesapeake City Md

15 Filed May 15, 1915 J. Frank Frazer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 15, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 15, 1915, to May 15, 1915

that stillborn alive on May 15, 1915

and that death occurred on the date stated above, at \_\_\_\_\_ m.

The CAUSE OF DEATH\* was as follows:

Stillborn - Premature birth  
Mother frequent 7 mo.

Contributory factors had nephritis  
Secondary  
ascoli - (Duration) yrs. mos. ds.

(Signed) Elwood J Kirk M. D.  
5/15, 1915 (Address) Ecklon Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and, (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. in the State yrs. mos. ds.

Where was disease contracted, \_\_\_\_\_ if not at place of death?

Former or usual residence. —

19 PLACE OF BURIAL OR REMOVAL Chesapeake City Md DATE OF BURIAL 5/16, 1915

20 UNDERTAKER J. E. Lepper. ADDRESS Chesapeake City

If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Moscaes*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Brachopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Confinement," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1915

BUREAU U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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**1 PLACE OF DEATH**

County Cecil

6470

**STATE OF MARYLAND  
CERTIFICATE OF DEATH**

Registration Dist. No. 96

St.; Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Principio Furnace (No.)

**2 FULL NAME**

**PERSONAL AND STATISTICAL PARTICULARS**

**3 SEX** Female **4 COLOR OR RACE** White **5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED** Married  
(Write the word)

**6 DATE OF BIRTH** Feb 18<sup>th</sup>, 1862  
(Month) (Day) (Year)

**7 AGE** 53 yrs. 3 mos. ds. If LESS than  
1 day.....hrs.  
OR.....min.?

**8 OCCUPATION**  
(a) Trade, profession, or  
particular kind of work House wife  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer) House work

**9 BIRTHPLACE**  
(State or country) Cecil Co Md

**10 NAME OF  
FATHER** Sam'l Winchester

**11 BIRTHPLACE  
OF FATHER**  
(State or country) Cecil Co Md

**12 MAIDEN NAME  
OF MOTHER** Mary Chumley

**13 BIRTHPLACE  
OF MOTHER**  
(State or country) Cecil Co Md

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant) Mary C Craig

(Address) Principio Furnace

**15**

Filed May 19 - 1915 - St. L. Cannon

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

**MEDICAL CERTIFICATE OF DEATH**

**16 DATE OF DEATH** May 17<sup>th</sup>, 1915  
(Month) (Day) (Year)

**17** I HEREBY CERTIFY, That I attended deceased from May 18<sup>th</sup> 1915, 1915, to May 20, 1915, 1915,  
that I last saw h. alive on May 18<sup>th</sup>, 1915,  
and that death occurred on the date stated above, at 10.30 P.M.

The CAUSE OF DEATH\* was as follows:

Valvular Heart Disease

(Duration) 10 yrs. .... mos. .... ds.  
Contributory Hypertension  
Secondary

(Signed) Ch. W. Steenick, M. D.  
May 19<sup>th</sup>, 1915 (Address) Baltimore Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)**

At place \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. In the  
of death \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds. State \_\_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.

Where was disease contracted,  
if not at place of death?

Former or  
usual residence.

**19 PLACE OF BURIAL OR REMOVAL**

Ebenezer Cemetery May 20, 1915

**20 UNDERTAKER**

W. Clifton Jackson Baltimore Md

**DATE OF BURIAL**

**ADDRESS**

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner, (b) Cotton mill; (a) Salesman, (b) Grocery; (a) Foreman, (b) Automobile factory.* The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer, Farm laborer, Laborer—Coal mine, etc.* Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife, Housework, or At Home, and children, not gainfully employed, as At school or At home.* Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant, Cook, Housemaid, etc.* If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) infection need not be stated unless important. Example: Measles (disease causing death), 29 d.s.; Bronchopneumonia (secondary), 10 d.s. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marsupium," "Old Age," "Shock," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Recover wound of head—Homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED

JUN 5 1915

BUREAU, V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

6471

64

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96Village or City Colera (No. ....)

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

Samuel Deloslain McCullough

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male White

4 COLOR OR RACE

5 SINGLE, MARRIED, ✓  
WIDOWED,  
DIVORCED  
(Write the word)

6 DATE OF BIRTH

Aug 29 (Month) 1885 (Year)

(Day)

7 AGE

59 yrs 9 mos 28 ds. It LESS than  
1 day, \_\_\_\_\_.hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.Farmer

## 9 BIRTHPLACE

(State or country)

North East

## PARENTS

## 10 NAME OF FATHER

John Johnson

## 11 BIRTHPLACE OF FATHER

(State or country)

Unknown

## 12 MAIDEN NAME OF MOTHER

Elizabeth Tull

## 13 BIRTHPLACE OF MOTHER

(State or country)

Unknown

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Elwood Adams

(Address)

Bellevue Hospital

15

Filed May 29, 1915 - M.C. Daemaw

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 28, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from May 28, 1915, to May 28, 1915,that I last saw him alive on May 27, 1915,and that death occurred on the date stated above, at 8:30 A.M.

The CAUSE OF DEATH\* was as follows:

apoplexyContributory Exhaustion  
Secondary

(Duration) yrs. mos. ds.

(Signed) Ernest Rutherford, M.D.,  
May 28, 1915 (Address) Liberty Mor Md

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?Former or  
usual residence.19 PLACE OF BURIAL OR REMOVAL West Nottingham DATE OF BURIAL May 31, 191520 UNDERTAKER Slater B. York

ADDRESS

Colera Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Houswife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum, etc.*, *Carcin-*

oma, Sarcoma, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *splinter, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED
JUN 5 1915
BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH		6472
County <u>Cecil</u>		(172)
Village or City <u>Ecklin</u> (No.)		
2 FULL NAME <u>Annie Elizabeth M Donell</u>		
PERSONAL AND STATISTICAL PARTICULARS		
3 SEX <u>Female</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, DIVORCED (Write the word) <u>Married</u>
6 DATE OF BIRTH <u>No information</u> (Month) <u>1</u> (Day) <u>1</u> (Year)		
7 AGE <u>68 yrs</u>	If LESS than 1 day, hrs. OR min. ?	
8 OCCUPATION (a) Trade, profession, or particular kind of work... <u>Houswife</u> (b) General nature of industry, business, or establishment in which employed (or employer) <u></u>		
9 BIRTHPLACE (State or country) <u>Maryland</u>		
10 NAME OF FATHER <u>No information</u>		
11 BIRTHPLACE OF FATHER (State or country) <u>No information</u>		
12 MAIDEN NAME OF MOTHER <u>No information</u>		
13 BIRTHPLACE OF MOTHER (State or country) <u>No information</u>		
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Wm M. Donell</u> (Address) <u>Ecklin Md</u>		
15 Date <u>May 3, 1915</u>		Time <u>Transit Train</u>

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 2  
(Month) May (Day) 2 (Year) 191517 I HEREBY CERTIFY, That I attended deceased from April 20, 1915, to May 2, 1915,that I last saw her alive on May 2, 1915,and that death occurred on the date stated above, at 4 P.M.

The CAUSE OF DEATH\* was as follows:

Rephroductive (Obstetric)  
Dilation of Heart  
(Duration) yrs. 6 mos. 10 days.

Contributory Chronic nephritis  
Secondary

(Signed) Helen Mitchell, M.D. (Address) Ellis Rd  
May 4, 1915 (Duration) yrs. 6 mos. 10 days.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Ecklin Cemetery DATE OF BURIAL May 5, 191520 UNDERTAKER Orange WaffenADDRESS Ecklin Md.

(If more blanks are needed, address State Registrar, 6 E. Franklin St., Baltimore, Requesting V. S. No. 1.)

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcinoma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congentital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*TUERPERAL scrophularia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as PROBABLY such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 4 1915

AMERICAN MEDICAL ASSOCIATION

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil  
Village or City Elkton

6473

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME Hiland L Marcus

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Married</u> (Write the word)
6 DATE OF BIRTH <u>No information</u>		If LESS than 1 day, hrs. OR min. ?
		(Month) <u>1840</u> (Day) (Year)

7 AGE <u>75</u>	yrs.      mos.      ds.
-----------------	-------------------------

8 OCCUPATION (a) Trade, profession, or particular kind of work... <u>Haschman</u>	(b) General nature of industry, business, or establishment in which employed (or employer) <u>Road crossing gate</u>
---	---

9 BIRTHPLACE (State or country) <u>Maryland</u>
--

10 NAME OF FATHER <u>James Marcus</u>
---------------------------------------

11 BIRTHPLACE OF FATHER (State or country) <u>Maryland</u>
---

12 MAIDEN NAME OF MOTHER <u>Mary Givoric</u>
--

13 BIRTHPLACE OF MOTHER (State or country) <u>Maryland</u>
---

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Mrs Hiland Marcus  
(Address) Elkton Md

15 Filed May 11th, 1915 by Frank Frazer

REGISTRAR

(1) If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 9, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from for past 2 yrs 191..., to May 9, 1915, that I last saw him alive on May 9, 1915, and that death occurred on the date stated above, at 8 A.m. The CAUSE OF DEATH\* was as follows:

Chronic Bright's Disease  
(Duration) yrs. mos. ds.

Contributory  
Secondary

D. Hawley, M.D.  
(Duration) yrs. mos. ds.  
(Signed) Elkton Md  
, 1st (Address)

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted,  
if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Elkton Cemetery DATE OF BURIAL May 12, 1915

20 UNDERTAKER Vinsinger & Pipkin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive Civil engineer*, *Stationary foreman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Contingent," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 4 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

6474

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Providence (No. \_\_\_\_\_)

## 2 FULL NAME

Joseph Francklin Miller

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Male</u>	4 COLOR OR RACE <u>white</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Single</u> (Write the word)
-------------------	------------------------------	---

## 6 DATE OF BIRTH

May 19, 1914  
(Month) (Day) (Year)

## 7 AGE

11 mos. 19 If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of Industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

California

## PARENTS

## 10 NAME OF FATHER

Allan Miller11 BIRTHPLACE OF FATHER  
(State or country)Delaware

## 12 MAIDEN NAME OF MOTHER

Helen Keithley13 BIRTHPLACE OF MOTHER  
(State or country)Mossgrove

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

Allan Miller

(Address)

Bethel Md.

## 15

Filed May 8, 1915By Paul Roger

REGISTRAR

(30)

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 8, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

Apr 1915 to May 7, 1915  
that I last saw him alive on May 7, 1915

and that death occurred on the date stated above, at 3 a.m.

The CAUSE OF DEATH\* was as follows:

Tuberculosis meningitis(Duration) yrs. 11 mos. - ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) C. P. Carrico, M. D.  
May 8, 1915 (Address) Easton Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,

If not at place of death?

Former or usual residence

19 PLACE OF BURIAL OR REMOVAL Cherry Cemetery, May 10, 1915 (Date of Burial)20 UNDERTAKER A. J. Abemathy ADDRESS Cherry Hill

(1) If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry; and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Oat mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcome, etc., of.....* (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anesthesia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Con genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Mastitis," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicæmia*," "*PUERPERAL peritonitis*," etc. State cause for such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis, tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

<b>RECEIVED</b>
JUN 4 1915
BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
Cecil County

6475

79

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 74

Village or City near Bay View Md (No.)  
St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

2 FULL NAME  
*Mary Ann Payne*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Female	4 COLOR OR RACE White	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) Married
-----------------	--------------------------	---

6 DATE OF BIRTH  
Oct 30 (Month) 1850 (Day) 1850 (Year)

7 AGE  
58 yrs. 6 mos. 28 ds. If LESS than  
1 day,.....hrs.  
OR min. ?

8 OCCUPATION  
(a) Trade, profession, or particular kind of work  
Housewife  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)  
England

10 NAME OF FATHER  
Stanford Dewberry

11 BIRTHPLACE OF FATHER  
(State or country)  
England

12 MAIDEN NAME OF MOTHER  
Mary Walters

13 BIRTHPLACE OF MOTHER  
(State or country)  
England

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant)  
Isaac Payne

(Address)  
Bay View Md

15 Filed May 29, 1915 Deacid-Biddle  
Local

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH  
May 28th, 1915 (Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 28th, 1915 to May 28th, 1915, that I last saw her alive on May 28th, 1915, and that death occurred on the date stated above, at 6 A. m. The CAUSE OF DEATH\* was as follows:

*Mitral Regurgitation*

(Duration) yrs. mos. ds.

Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) C. B. Gaeling, M. D.  
May 29, 1915 (Address) North East, Md.

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL  
Bethel Cemetery DATE OF BURIAL  
May 31, 1915

20 UNDERTAKER  
Vinsinger Pippin ADDRESS  
Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc. without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Hausmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc. of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Baltimore

6476

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Baltimore (No. ....)2 FULL NAME Rebecca Pierce

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>Female</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>widow</u>
---------------------	------------------------------	---

6 DATE OF BIRTH

12      9, 1843  
(Month)    (Day)    (Year)

7 AGE

71 yrs. 4 mos. 24 ds.  
If LESS than  
1 day.....hrs.  
OR .....min.?

8 OCCUPATION

- (a) Trade, profession, or particular kind of work. Housewife
- (b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Pennsylvania

10 NAME OF FATHER

Philip Conselman11 BIRTHPLACE OF FATHER  
(State or country)Pennsylvania

12 MAIDEN NAME OF MOTHER

Dout Brown13 BIRTHPLACE OF MOTHER  
(State or country)Dout Brown

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

George L. Pierce

(Address)

Goshen Cemetery Cor

15

Filed

1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 3, 1915  
(Month)    (Day)    (Year)

I HEREBY CERTIFY, That I attended deceased from March 15, 1915, to May 3, 1915,

that I last saw her alive on May 2, 1915,

and that death occurred on the date stated above, at 6 a.m.,

The CAUSE OF DEATH\* was as follows:

Hemiplegia(Duration) yrs. 1/2 mos. .... ds.Contributory Fatty degeneration of  
Secondary heart(Duration) 9 yrs. .... mos. .... ds.(Signed) John P. Miller, M.D.  
May 5, 1915 (Address) North East, Md.

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death .... yrs. .... mos. .... ds. In the State .... yrs. .... mos. .... ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL

Baptist Cemetery May 6, 1915

20 UNDERTAKER

Samuel Taylor, Roxbury

DATE OF BURIAL

ADDRESS

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Hauskeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer*,

*oma, Sarcoma, etc., of . . . . . (name origin; "Cancer" is less definite; avoid use of "Tumor", for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPERAL septicæmia," "PUERPERAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deatius state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railway train—accident; Revolver wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 3 1915

13 U.S.R.V.A.U.V.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Breck

6477

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 96

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Port Deposit (No. ....)

(29)

2 FULL NAME Hannah Maria Scott

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX	4 COLOR OR RACE	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word)
<u>female</u>	<u>Colored</u>	<u>Married</u>

6 DATE OF BIRTH  
March 8, 1873  
(Month) (Day) (Year)

7 AGE  
42 yrs. 2 mos. 4 ds. If LESS than  
1 day, \_\_\_\_\_.hrs.  
OR \_\_\_\_\_.min.?

8 OCCUPATION  
(a) Trade, profession, or  
particular kind of work  
Housewife  
(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country)  
Breck Co Md

10 NAME OF  
FATHER  
Josiah Black

11 BIRTHPLACE  
OF FATHER  
(State or country)  
Breck Co Md

12 MAIDEN NAME  
OF MOTHER  
Hannah P Brown

13 BIRTHPLACE  
OF MOTHER  
(State or country)  
Breck Co Md

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Philip Scott

(Address) Port Deposit Md

15 Filed May 18, 1915 A.R. Baumer

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May - 12<sup>th</sup>, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
Apr. 30 1915 to May 11, 1915  
that I last saw her alive on May 11, 1915

and that death occurred on the date stated above, at 2:03 P.M.

The CAUSE OF DEATH\* was as follows:

Miliary Tuberculosis

(Duration) yrs. 1 1/2 mos. 0 ds.

Contributory  
Secondary

(Signed) 69. Bergman (Address) Port Deposit Md.  
May 13, 1915

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Bethel DATE OF BURIAL 5-15, 1915

20 UNDERTAKER Slater B. Loh ADDRESS Colona Md

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

(1)

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age.

For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mining*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con genital," "Seizure," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably voluntary*, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *synsis,ictus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



RECEIVED  
JUN 5 1915  
BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

6478

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Village or City

Ektton Union HospitalRegistration Dist. No. 92

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

John Sewell

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX Male 4 COLOR OR RACE colored 5 SINGLE, MARRIED, WIDOWED, OR DIVORCED named  
(Write the word)

## 6 DATE OF BIRTH

No information, 1,  
(Month) (Day) (Year)

## 7 AGE

70 yrs. — mos. — ds. If LESS than  
1 day, hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or particular kind of work. Farmer

(b) General nature of industry, business, or establishment in which employed (or employer)

## 9 BIRTHPLACE

(State or country) Maryland

## 10 NAME OF FATHER

John Sewell Jr

## 11 BIRTHPLACE OF FATHER

(State or country) Maryland

## 12 MAIDEN NAME OF MOTHER

No information

## 13 BIRTHPLACE OF MOTHER

(State or country) No information

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) John T. Sewell

## (Address)

Ektton Md

## 15

May 5, 1915

Filed

1915

J. Brown Frazer

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

May 3

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from April 19, 1915, to May 3, 1915,that I last saw him alive on May 3, 1915,and that death occurred on the date stated above, at 10 P.M.,

The CAUSE OF DEATH\* was as follows:

Diseases of Heart(Duration) yrs. mos. 1/2 ds.Contributory Other Secondary Bacteremia forCause 4/20/15 (Duration) yrs. mos. ds.(Signed) Hannah Metallo, M. D. Elkton (Address) ElktonMay 4, 1915 (Address) Elkton

\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) WHETHER ACCIDENTAL, SUICIDAL, OR HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ Where \_\_\_\_\_  
of death yrs. mos. 21 ds. In the State 70 yrs. mos. dsWhere was disease contracted, if not at place of death? near Elkton MdFormer or usual residence. near Elkton Md.19 PLACE OF BURIAL OR REMOVAL Panthers Field Cherry Hill DATE OF BURIAL May 5, 1915

## 20 UNDERTAKER

Vinson & Peppin ADDRESS Elkton Md

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Houseworker*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy" "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *esisis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1915

BUREAU, U. S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N.B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County..... *Baltimore*

6479

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. *90*

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City..... *Rising Sun Md.*

St.: ..... Ward)

2 FULL NAME..... *John W. Stewett, Jr.*

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

*Male*

4 COLOR OR RACE

*White*5 SINGLE,  
MARRIED,  
WOOED,  
OR DIVORCED  
(Write the word)*Single*

6 DATE OF BIRTH

*March 11, 1906*  
(Month) (Day) (Year)

7 AGE

*9 yrs. 2 mos. 15 ds.*If LESS than  
1 day, .... hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or  
particular kind of work*None*(b) General nature of Industry,  
business, or establishment in  
which employed (or employer)*None*

9 BIRTHPLACE

(State or country)

10 NAME OF  
FATHER11 BIRTHPLACE  
OF FATHER  
(State or country)12 MAIDEN NAME  
OF MOTHER13 BIRTHPLACE  
OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant)

(Address)

15

• Filed

191

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

*May 26th, 1915*  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from

*May 20th, 1915, to May 26th, 1915,*  
that I last saw him alive on *May 25th at 10 pm*, 1915...and that death occurred on the date stated above, at *1:15 pm*.

The CAUSE OF DEATH\* was as follows:

*Influenza and of the  
lungs*

(Duration) yrs. 8 mos. 0 ds.

Contributory *General debility*  
Secondary

Exacerbation (Duration) yrs. 0 mos. 7 ds.

(Signed)

*George S. Darr, M. D.**May 27, 1915 (Address) Rising Sun Md.*\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT  
CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI-  
DENTAL, SUICIDAL, or HOMICIDAL.18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS,  
OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted,  
if not at place of death?Former or  
usual residence.

19 PLACE OF BURIAL OR REMOVAL

*Local Mortuary* May 27, 1915

20 UNDERTAKER

*Daniel B. Taylor & Sons* ADDRESS

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

1

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

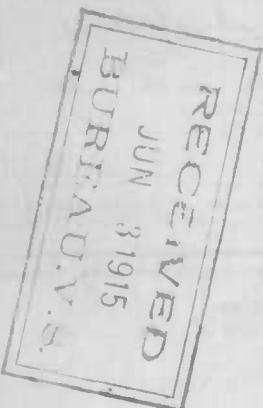
**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritoneum*, etc., *Gastric*,

oma, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic tubular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 d.; *Bronchopneumonia* (secondary), 10 d. Never report mere symptoms or terminal conditions, such as "Anemia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicemia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.



## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

## 1 PLACE OF DEATH

County Cecil

6480

103

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Registration Dist. No. 92

St.: \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Elkton (No. ....)

## 2 FULL NAME

Mary M. Thomas

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Female Colored

5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)

Married

## 6 DATE OF BIRTH

March 5<sup>th</sup>, 1881

(Month) (Day) (Year)

## 7 AGE

34 yrs. 1 mos. 4 ds.

If LESS than  
1 day, ..... hrs.  
OR min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.

(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

House wife

## 9 BIRTHPLACE

(State or country)

Harry De Graw and

## 10 NAME OF FATHER

James Wise

## 11 BIRTHPLACE OF FATHER

(State or country)

No information

## 12 MAIDEN NAME OF MOTHER

No information

## 13 BIRTHPLACE OF MOTHER

(State or country)

No information

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Wm Thomas

(Address) Elkton, Md

## 15

Filed May 8, 1915

J. Frank Frazer

REGISTRAR

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

May 8, 1915

(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from May 7<sup>th</sup>, 1915, to May 8<sup>th</sup>, 1915, that I last saw her alive on May 7<sup>th</sup>, 1915, and that death occurred on the date stated above, at 3 P.M.. The CAUSE OF DEATH\* was as follows:

Syncope

(Duration) yrs. mos. ds.

Contributory Acute Card. affection  
Secondary Heart failure (Duration) yrs. mos. ds.

(Signed) Stella W. Morris, M.D.  
May 8, 1915 (Address) Elkton

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds

Where was disease contracted, if not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Elkton Colored Cemetery DATE OF BURIAL May 9, 1915

20 UNDERTAKER U.S. Caskets & Supply ADDRESS Elkton

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "As-thenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL septicemia*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 1 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

1 PLACE OF DEATH County <u>Cecil</u>		6481	186	STATE OF MARYLAND CERTIFICATE OF DEATH	
Village or City <u>Perryville</u> (No.)				Registration Dist. No. <u>96</u>	
St.: Ward)				[If death occurred in a hospital or institution, give its NAME instead of street and number.]	
2 FULL NAME <u>James L. Ward</u>					
PERSONAL AND STATISTICAL PARTICULARS					
3 SEX <u>Male</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED <u>Widowed</u> (Write the word)			
6 DATE OF BIRTH <u>March 13, 1833</u> (Month) (Day) (Year)					
7 AGE <u>82 yrs. 2 mos. 15 ds.</u>	If LESS than 1 day.....hrs. OR.....min.?				
8 OCCUPATION (a) Trade, profession, or particular kind of work. <u>Farmer</u>					
(b) General nature of industry, business, or establishment in which employed (or employer) <u>Farmer</u>					
8 BIRTHPLACE (State or country) <u>Cecil Co Ind</u>					
10 NAME OF FATHER <u>Wm Ward</u>					
11 BIRTHPLACE OF FATHER (State or country) <u>Cecil Co Ind</u>					
12 MAIDEN NAME OF MOTHER <u>Sarah Parkinson</u>					
13 BIRTHPLACE OF MOTHER (State or country) <u>Cecil Co Ind</u>					
14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE (Informant) <u>Clara Ward</u> (Address) <u>Perryville Ind</u>					
15 Filed <u>May 31, 1915</u>	REGISTRAR		DATE OF BURIAL		
If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.					
MEDICAL CERTIFICATE OF DEATH					
16 DATE OF DEATH <u>May 28, 1915</u> (Month) (Day) (Year)					
17 I HEREBY CERTIFY, That I attended deceased from <u>April 23, 1915</u> , to <u>May 28, 1915</u> , that I last saw him alive on <u>May 28, 1915</u> , and that death occurred on the date stated above, at <u>8 a.m.</u> , The CAUSE OF DEATH* was as follows: <u>Advanced prostate gland &amp;</u> <u>on of cystitis</u>					
(Duration) yrs. <u>4</u> mos. <u>0</u> ds.					
Contributory <u>Old age</u> Secondary					
(Duration) yrs. <u>0</u> mos. <u>0</u> ds.					
(Signed) <u>Geo. M. Slane</u> , M. D. <u>May 30, 1915</u> (Address) <u>Perryville Ind</u>					
* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCI- DENTAL, SUICIDAL, or HOMICIDAL.					
18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS) At place _____ Where was disease contracted, of death _____ yrs. _____ mos. _____ ds. In the _____ If not at place of death? _____ State _____ yrs. _____ mos. _____ ds					
Former or usual residence _____					
19 PLACE OF BURIAL OR REMOVAL <u>Principio Cemetery</u> DATE OF BURIAL <u>May 31, 1915</u>					
20 UNDERTAKER <u>W C Jackson Bladensburg</u> ADDRESS					

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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(a) *Spinner*; (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer*—*Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc.*, *Carcin-*

*oma, Sarcoma, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); Measles; Whooping cough; Chronic valvular heart disease; Chronic interstitial nephritis, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: Measles (disease causing death), 29 ds.; Bronchopneumonia (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shocks," "Tetraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "PUERPEAL septicemia," "PUERPEAL peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OF INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: Accidental drowning; Struck by railroad train—accident; Recover wound of head—homicide; Poisoned by carbolic acid—probably suicide. The nature of the injury, as fracture of skull, and consequences (e. g., sepsis, tetanus) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)*

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RECEIVED	JUN 5 1915
BUREAU OF THE CENSUS	

**N. B.—** Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

**1 PLACE OF DEATH**  
County..... Cecil

Village or City Appleton (No.)

**2 FULL NAME** Charles F. Wildman

# STATE OF MARYLAND CERTIFICATE OF DEATH

Registration Dist. No. 92

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## PERSONAL AND STATISTICAL PARTICULARS

<b>3 SEX</b>	<b>4 COLOR OR RACE</b>	<b>5 SINGLE, MARRIED, WIDOWED OR DIVORCED</b> (Write the word)
<u>M</u>	<u>We</u>	<u>S</u>

**6 DATE OF BIRTH**

Feb 16, 1847  
(Month) (Day) (Year)

**7 AGE**

68 yrs. 2 mos. 18 ds.  
If LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

**8 OCCUPATION**

- (a) Trade, profession, or particular kind of work:
- (b) General nature of industry business, or establishment in which employed (or employer):

Retired

**9 BIRTHPLACE**  
(State or country)

Penn.

**10 NAME OF FATHER**

Joseph Wildman

**11 BIRTHPLACE OF FATHER**  
(State or country)

Penn.

**12 MAIDEN NAME OF MOTHER**

Harriet Eley

**13 BIRTHPLACE OF MOTHER**  
(State or country)

Penn.

**14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE**

(Informant)

J. E. Wood Zebley

(Address)

Appleton Md.

**15**

Filed May 5<sup>th</sup>, 1915 J. Frank Fraser

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

**16 DATE OF DEATH**

May 3<sup>d</sup>, 1915  
(Month) (Day) (Year)

**17 I HEREBY CERTIFY, That I attended deceased from**  
March 1, 1915, to May 3<sup>d</sup>, 1915,  
that I last saw him alive on May 2<sup>d</sup>, 1915,  
and that death occurred on the date stated above, at \_\_\_\_\_.  
The CAUSE OF DEATH \* was as follows:

Myocarditis Chronic

(Duration) 1 yr. \_\_\_\_ mos. \_\_\_\_ ds.  
Contributory Secondary Carcinoma of Pancreas

(Duration) 2 yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
(Signed) F. Wilson Jr. M. D.

5/14/1915 (Address) Kimberlyville Pa.  
\* State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL or HOMICIDAL.

**18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)**

At place of death \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Where was disease contracted,  
if not at place of death?

In the State, \_\_\_\_ yrs. \_\_\_\_ mos. \_\_\_\_ ds.  
Former or usual residence

**19 PLACE OF BURIAL OR REMOVAL**

Head of Christian Rd.

**DATE OF BURIAL**

May 6, 1915

**20 UNDERTAKER**

E. Wilson

**ADDRESS**

Newark Del.

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of Cause of Death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebro-spinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*. *Bronchopneumonia* ("Pneumonia", unqualified, is indefinite); *Tuberculosis of lungs*, *mенин-*

ges, peritonaeum, etc., *Carcinoma*, *Sarcoma*, etc., of . . . . . (name origin); "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Moskes*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), *29 ds.*; *Bronchopneumonia* (secondary), *10 ds.* Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia," (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility," ("Con genital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uremia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from child-birth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state MEANS OR INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as probably such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JULY 1 1915

BUREAU, U.S.

RECEIVED	RECEIVED
JULY 1 1915	
BUREAU, U.S.	

*sent out for signature*

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

N. B.—Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See Instructions on back of certificate.

1 PLACE OF DEATH  
County Cecil

6483

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92

St. \_\_\_\_\_ Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Elkton (No. ....)

## 2 FULL NAME

G. Hartley Williams

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>26</u>	4 COLOR OR RACE <u>White</u>	5 SINGLE, MARRIED, WIDOWED, OR DIVORCED (Write the word) <u>Single</u>
-----------------	------------------------------	--

6 DATE OF BIRTH No information  
(Month) (Day) (Year)

7 AGE <u>26</u> yrs. .... mos. .... ds.	If LESS than 1 day, .... hrs. OR .... min. ?
--	--

8 OCCUPATION  
 (a) Trade, profession, or  
particular kind of work Harmer  
 (b) General nature of industry,  
business, or establishment in  
which employed (or employer)

9 BIRTHPLACE  
(State or country) Maryland

10 NAME OF FATHER <u>Ambrose Williams</u>
11 BIRTHPLACE OF FATHER (State or country) <u>No information</u>
12 MAIDEN NAME OF MOTHER <u>No information</u>
13 BIRTHPLACE OF MOTHER (State or country) <u>No information</u>

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE  
(Informant) Daniel Guckel  
(Address) Newport News Va

15 May 10, 1915 J. Paul Taylor  
FILED REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH May 7, 1915  
(Month) (Day) (Year)

17 I HEREBY CERTIFY, That I attended deceased from  
April 22, 1915, to May 7, 1915,

that I last saw him alive on May 7, 1915,

and that death occurred on the date stated above at 2 P.M.

The CAUSE OF DEATH\* was as follows:

Typhoidal fever

(Duration) yrs. 1 mos. 0 ds.

Contributory  
Secondary

(Duration) yrs. 0 mos. 0 ds.  
(Signed) W. T. Morrison, M.D.  
May 8, 1915 (Address) Elkton, Md.

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. 14 mos. 0 ds. In the State yrs. 3 mos. 0 ds.

Where was disease contracted, if not at place of death?

Former or usual residence Newport News Va

19 PLACE OF BURIAL OR REMOVAL Walnuton Ave DATE OF BURIAL May 10, 1915

20 UNDERTAKER Vassie & Pipkin ADDRESS Elkton Md.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balt., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*; *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcinoma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Hemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal poritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of INJURY and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

**RECEIVED**  
JUN 4 1915  
BUREAU, V.S.

## MARGIN RESERVED FOR BINDING

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Ocic

6484

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 92St. Ward)

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Elkton (No. ....)2 FULL NAME Loy L. Wilson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX <u>M</u>	4 COLOR OR RACE <u>Colored</u>	5 SINGLE, MARRIED, WIDWED, OR DIVORCED <u>MARRIED</u> (Write the word)
----------------	--------------------------------	---

6 DATE OF BIRTH

Aug 24, 1882  
(Month) (Day) (Year)

7 AGE

93 yrs. .... mos. .... ds. If LESS than  
1 day, .... hrs.  
OR min. ?

8 OCCUPATION

(a) Trade, profession, or particular kind of work Herrman.  
(b) General nature of industry, business, or establishment in which employed (or employer)

9 BIRTHPLACE  
(State or country)Virginia  
Ed Johnson

PARENTS

10 NAME OF FATHER

11 BIRTHPLACE OF FATHER  
(State or country)

12 MAIDEN NAME OF MOTHER

13 BIRTHPLACE OF MOTHER  
(State or country)

14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Herrman Wilson(Address) Elkton Md

15

Filed May 25 1915 J. Frank Fraser

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 24, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from Oct 15<sup>th</sup>, 1914, to May 21<sup>st</sup>, 1915that I last saw her alive on May 21<sup>st</sup>, 1915  
and that death occurred on the date stated above, at Elkton.

The CAUSE OF DEATH\* was as follows:

Tuberculosis

(Duration) — yrs. 9 mos. 0 ds.

Contributory  
Secondary

(Duration) — yrs. 0 mos. 0 ds.

(Signed) J. Frank Fraser, M. D.  
May 25<sup>th</sup> 1915 (Address) Elkton

State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS; TRANSIENTS, OR RECENT RESIDENTS)

At place of death ..... yrs. ..... mos. ..... ds. In the State ..... yrs. ..... mos. ds.  
Where was disease contracted,  
If not at place of death?

Former or usual residence.

19 PLACE OF BURIAL OR REMOVAL Elkwood Rd DATE OF BURIAL May 26, 191520 UNDERTAKER James Marshall, Elkton

ADDRESS

# REVISED UNITED STATES STANDARD

## CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

**Statement of occupation**—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. The question applies to each and every person, irrespective of age. For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples: (a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Maugger," "Dealer," etc., without more precise specification as *Day laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housemaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer (retired 6 yrs.)* For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is Indefinite); *Tuberculosis of lungs, meninges, peritonaeum*, etc., *Carcin-*oma, *Sarcoma*, etc., of..... (name origin); "Can-  
cer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Ast-  
themia," "Anaemia" (merely symptomatic), "Atrophy," "Collapse," "Convulsions," "Debility" ("Con-  
genital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "Puerperal septicæmia," "Puerperal peritonitis," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *sepsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

If this certificate is looked over thoroughly and all questions answered in detail, it will prevent further correspondence. All the data is essential and must be obtained before the certificate is permanently filed.

RECEIVED

JUN 4 1915

BUREAU, U.S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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1 PLACE OF DEATH  
County Cecil

6485

STATE OF MARYLAND  
CERTIFICATE OF DEATH

Village or City

Elkton Union HospitalRegistration Dist. No. 92

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

## 2 FULL NAME

(No.)

Robert Wilson

## PERSONAL AND STATISTICAL PARTICULARS

3 SEX

Male

4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widow

6 DATE OF BIRTH

No information

(Month)

(Day)

(Year)

7 AGE

80

yrs.

mos.

ds.

If LESS than  
1 day, ..... hrs.  
OR ..... min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of workNone(b) General nature of industry,  
business, or establishment in  
which employed (or employer)

## 9 BIRTHPLACE

(State or country)

No information

## PARENTS

## 10 NAME OF FATHER

No information11 BIRTHPLACE OF FATHER  
(State or country)No information

## 12 MAIDEN NAME OF MOTHER

No information13 BIRTHPLACE OF MOTHER  
(State or country)No information

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) W C Jackson

(Address)

Blythe Dale

15

Filed May 28, 1915 by Frank Dager

REGISTRAR

(1) If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

## MEDICAL CERTIFICATE OF DEATH

16 DATE OF DEATH

May 28

(Year)

(Month)

(Day)

17 I HEREBY CERTIFY, That I attended deceased from

May 16, 1915, to May 28, 1915,that I last saw him alive on May 27, 1915,and that death occurred on the date stated above, at 10 a.m.

The CAUSE OF DEATH\* was as follows:

Broncos - pneumoniaIndefinite (Duration) yrs. mos. ds.Contributory  
Secondary

(Duration) yrs. mos. ds.

(Signed) Howard Bratton, M. D.May 28, 1915 (Address) Elkton Md

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place of death yrs. mos. ds. In the State yrs. mos. ds.

Where was disease contracted, if not at place of death?

Former or usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Cash & DagerDATE OF BURIAL May 30, 1915

## 20 UNDERTAKER

Vincent PhippsADDRESS Elkton Md

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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For many occupations a single word or term on the first line will be sufficient, e. g., *Farmer* or *Planter*, *Physician*, *Compositor*, *Architect*, *Locomotive engineer*, *Civil engineer*, *Stationary fireman*, etc. But in many cases, especially in industrial employments, it is necessary to know (a) the kind of work and also (b) the nature of the business or industry, and therefore an additional line is provided for the latter statement; it should be used only when needed. As examples:

(a) *Spinner*, (b) *Cotton mill*; (a) *Salesman*, (b) *Grocery*; (a) *Foreman*, (b) *Automobile factory*. The material worked on may form part of the second statement. Never return "Laborer," "Foreman," "Manager," "Dealer," etc., without more precise specification as *Dairy laborer*, *Farm laborer*, *Laborer—Coal mine*, etc. Women at home, who are engaged in the duties of the household only (not paid *Housekeepers* who receive a definite salary), may be entered as *Housewife*, *Housework*, or *At Home*, and children, not gainfully employed, as *At school* or *At home*. Care should be taken to report specifically the occupations of persons engaged in domestic service for wages, as *Servant*, *Cook*, *Housmaid*, etc. If the occupation has been changed or given up on account of the disease causing death, state occupation at beginning of illness. If retired from business, that fact may be indicated thus: *Farmer* (*retired 6 yrs.*) For persons who have no occupation whatever, write *None*.

**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Group"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs*, *meninges*, *peritonaeum*, etc., *Carcin-*

*oma*, *Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Masculitis*; *Whooping cough*; *Chronic valvular heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Example: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 70 ds. Never report mere symptoms or terminal conditions, such as "Asthenia," "Anaemia" (merely syncretic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsy," "Exhaustion," "Heart failure," "Haemorrhage," "Inanition," "Marasmus," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*PUERPERAL SEPTICACONIA*," "*PUERPERAL peritonitis*," etc. State cause for which surgical operation was undertaken. For violent death state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railroad train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (e. g., *scrosis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED

JUN 4 1915

BUREAU, U. S.

## WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD

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## 1 PLACE OF DEATH

County and

6486

64

STATE OF MARYLAND  
CERTIFICATE OF DEATHRegistration Dist. No. 95

St. \_\_\_\_\_ Ward \_\_\_\_\_

[If death occurred in a hospital or institution, give its NAME instead of street and number.]

Village or City Rising Sun (No. \_\_\_\_\_)

## 2 FULL NAME

David Zell.

## PERSONAL AND STATISTICAL PARTICULARS

## 3 SEX

Male

## 4 COLOR OR RACE

white5 SINGLE,  
MARRIED,  
WIDOWED,  
OR DIVORCED  
(Write the word)Widower

## 6 DATE OF BIRTH

Mar 31, 1838  
(Month) (Day) (Year)

## 7 AGE

27 yrs. 1 mos. 24 ds.IT LESS than  
1 day, \_\_\_\_ hrs.  
OR \_\_\_\_ min. ?

## 8 OCCUPATION

(a) Trade, profession, or  
particular kind of work.(b) General nature of industry,  
business, or establishment in  
which employed (or employer)Engineer

## 9 BIRTHPLACE

(State or country)

Lancaster Co. Pa.

## PARENTS

## 10 NAME OF FATHER

Harry Zell

## 11 BIRTHPLACE OF FATHER

(State or country)

Germany

## 12 MAIDEN NAME OF MOTHER

Don't know

## 13 BIRTHPLACE OF MOTHER

(State or country)

Don't know

## 14 THE ABOVE IS TRUE TO THE BEST OF MY KNOWLEDGE

(Informant) Milton S. Zell(Address) Rising Sun

## 15

Filed

1915

REGISTRAR

## MEDICAL CERTIFICATE OF DEATH

## 16 DATE OF DEATH

May 24, 1915  
(Month) (Day) (Year)17 I HEREBY CERTIFY, That I attended deceased from  
Aug 20-, 1914, to May, 1915,that I last saw him alive on May 10, 1915,  
and that death occurred on the date stated above, at 2 p.m.

The CAUSE OF DEATH\* was as follows:

Paralysis stroke(Duration) 9 yrs. 9 mos. 0 ds.Contributory  
Secondary(Duration) 0 yrs. 0 mos. 0 ds.

(Signed)

J. B. S. Zell, M. D.  
5/24, 1915 (Address) Rising Sun

\*State the DISEASE CAUSING DEATH, or, in deaths from VIOLENT CAUSES, state (1) MEANS OF INJURY; and (2) whether ACCIDENTAL, SUICIDAL, or HOMICIDAL.

## 18 LENGTH OF RESIDENCE (FOR HOSPITALS, INSTITUTIONS, TRANSIENTS, OR RECENT RESIDENTS)

At place \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds. In the State \_\_\_\_\_ yrs. \_\_\_\_\_ mos. \_\_\_\_\_ ds

Where was disease contracted,  
if not at place of death?Former or  
usual residence

## 19 PLACE OF BURIAL OR REMOVAL

Union Chester Co. Pa. May 26, 1915  
DATE OF BURIAL

## 20 UNDERTAKER

B. E. Mason ADDRESS  
Nottingham  
A. K. Pa.

If more blanks are needed, address State Registrar, 6 E. Franklin St., Balto., Requesting V. S. No. 1.

# REVISED UNITED STATES STANDARD CERTIFICATE OF DEATH

[Approved by U. S. Census and American Public Health Association.]

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**Statement of cause of death**—Name, first, the disease causing death (the primary affection with respect to time and causation), using always the same accepted term for the same disease. Examples: *Cerebrospinal fever* (the only definite synonym is "Epidemic cerebrospinal meningitis"); *Diphtheria* (avoid use of "Croup"); *Typhoid fever* (never report "Typhoid pneumonia"); *Lobar pneumonia*; *Bronchopneumonia* ("Pneumonia," unqualified, is indefinite); *Tuberculosis of lungs, meninges, peritonaeum, etc., Cancer-*

*oma, Sarcoma*, etc., of..... (name origin; "Cancer" is less definite; avoid use of "Tumor" for malignant neoplasms); *Measles*; *Whooping cough*; *Chronic atrial heart disease*; *Chronic interstitial nephritis*, etc. The contributory (secondary or intercurrent) affection need not be stated unless important. Examples: *Measles* (disease causing death), 29 ds.; *Bronchopneumonia* (secondary), 10 ds. Never report mere symptoms or terminal conditions, such as "Anæmia," "Anæmia" (merely symptomatic), "Atrophy," "Collapse," "Coma," "Convulsions," "Debility" ("Congenital," "Senile," etc.), "Dropsey," "Exhaustion," "Heart failure," "Hæmorrhage," "Inanition," "Malaria," "Old Age," "Shock," "Uraemia," "Weakness," etc., when a definite disease can be ascertained as the cause. Always qualify all diseases resulting from childbirth or miscarriage as "*Puerperal septicæmia*," "*Puerperal peritonitis*," etc. State cause for which surgical operation was undertaken. For violent deaths state means of injury and qualify as ACCIDENTAL, SUICIDAL, or HOMICIDAL, or as *probably* such, if impossible to determine definitely. Examples: *Accidental drowning*; *Struck by railway train—accident*; *Revolver wound of head—homicide*; *Poisoned by carbolic acid—probably suicide*. The nature of the injury, as fracture of skull, and consequences (c. g., *scpsis*, *tetanus*) may be stated under the head of "Contributory." (Recommendations on statement of cause of death approved by Committee on Nomenclature of the American Medical Association.)

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RECEIVED
JUN 3 1915
BUREAU, U. S.